

## PROTECTIVE SUPERVISION 24-HOURS-A-DAY COVERAGE PLAN

PLEASE PRINT

NAME OF IHSS RECIPIENT:

RECIPIENT'S TELEPHONE #:

ADDRESS OF IHSS RECIPIENT:

NAME OF PRIMARY CONTACT RESPONSIBLE:

CONTACT'S TELEPHONE #:

RELATIONSHIP TO RECIPIENT:

As the primary contact for arranging the 24-hour-a-day coverage plan for the above named Recipient, I acknowledge my understanding of the following:

- A 24-hour-a-day coverage plan has been arranged and is in place.

*The continuous 24-hour-a-day coverage plan can be met regardless of paid In-Home Supportive Service (IHSS) hours along with various alternate resources (i.e.; Adult or Child Day Care Centers, community resource centers, Senior Centers, respite centers, etc.)*

- The 24-hour-a-day coverage plan will be provided at all times.
- If there is any change to the 24-hour-a-day coverage plan (i.e. hospitalization, attendance in day-care programs, travel, etc.) I will immediately **notify the IHSS social worker.**
- The above name Recipient has an established need for 24-hour-a-day Protective Supervision if he/she is to remain safely in the home. The IHSS social worker has also discussed with me the appropriateness of out-of-home care as an alternative to 24-hour-a-day Protective Supervision.

NAME OF CARE PROVIDER (1):

CONTACT PHONE #:

NAME OF CARE PROVIDER (2):

CONTACT PHONE #:

NAME OF CARE PROVIDER (3):

CONTACT PHONE #:

### Describe the implementation of the Protective Supervision 24-Hour-A-Day Coverage Plan:

SIGNATURE OF PRIMARY CONTACT RESPONSIBLE:

DATE:

SIGNATURE OF IHSS SOCIAL WORKER:

CONTACT PHONE #: